

**INSTRUCTIONS TO THE EMPLOYER UNIT
FOR COMPLETION OF THE ASRS LONG TERM DISABILITY
CLAIM PACKET**

1. After your employee has been off work for 3 months due to their disability, please give them the Employee LTD Claim Packet to complete. The packet should contain the following:
 - a. Cover Letter
 - b. Employee Claim Statement (Part 1 & 2)
 - c. Social Security Authorization
 - d. Request for information (ROI)
 - e. W-4
 - f. A4
 - g. Attending Physician's Statement
 - h. Answers to Commonly Asked Questions
2. Tell the employee to complete and sign the first six forms. Then, the employee will need to take the Attending Physician's Statement to their doctor's office and have their physician complete and sign those forms. Once this is done, all of the forms should be returned to you.
3. Once you receive a completed packet from the employee, you will need to complete and sign the Employer's Notice of Claim forms.
4. After steps 2 and 3 are done, you will need to forward the entire employee's packet, along with the Employer's Notice form to VPA at P.O. Box 9830, Calabasas, CA 91372-0830.
5. VPA will keep you informed of the status of the claim through Monthly Claims Activity Reports and with email notices of the claims when they are approved, denied or terminated. You can also call VPA's voice response unit at (800) 495-9301, 24 hours a day, 7 days a week, to find out the status of your employee's claim. The only information you will need is the employee's Social Security Number and year of birth. If you do not receive the information you are looking for through the voice response unit, you may call between the hours of 6:00 a.m. and 4:45 p.m. Pacific Time, Monday through Friday, to speak to a Customer Service Representative.
6. If you have any questions regarding the packet, how to complete it, etc., please feel free to call VPA at (800) 495-9301 and you will be walked through the process.
7. If you need additional packets, please visit the ASRS website at www.asrs.state.az.us. The packets are housed in the Employer section under Long Term Disability. If you do not have Internet access, please call (800) 495-9301, and follow the prompts. New packets will be sent to you within 48 hours.

ARIZONA STATE RETIREMENT SYSTEM

LONG-TERM DISABILITY INCOME PLAN

EMPLOYER'S NOTICE OF CLAIM



VPA, Inc.

Employer's Notice of Claim

- Be sure to answer all questions
- Please type or print
- Mail completed form to the address at the right

MAILING ADDRESS

VPA, Inc.
P.O. Box 9830
Calabasas, CA 91372-0830

TO BE COMPLETED BY THE EMPLOYER

New claim: ☐ Yes ☐ No

1. Full name of employee <i>(Please print)</i>		2. Date employed	3. Effective date of protection under ASRS plan														
4. Social Security number		6. Employee's normal work schedule in a fiscal year A. Period (s) covered by contract _____ B. Days per week _____ Hours per day _____ If you are a school district, has claimant signed a contract for the next school year? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of Pay periods per year _____															
5. Amount of salary as of date disability began for purpose of ASRS: \$ _____ Annual or Fiscal																	
7. Date last worked (no. of hours that date)	8. Reason for not working after this date	9. Date disability began															
10. Did this disability occur as a result of the claimant's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed If "Yes," or under dispute, please provide us with the policy number, name, address and phone number of Workers Compensation administrator																	
11. Have you and the claimant discussed reasonable accommodations which would allow a return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please explain.																	
12. Has employee resigned or been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give exact date? _____																	
13. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" on what date? _____ <input type="checkbox"/> Regular duties <input type="checkbox"/> With restrictions Current work schedule: _____ Days per week _____ Hours per day																	
14. Has the employee ever made a prior claim for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes" please provide date returned to work.)		15. Sick leave end date	16. Vacation pay end date														
17. Is the employee receiving Short-Term Disability or Mid-Term Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," are the premiums paid by the <input type="checkbox"/> Employee <input type="checkbox"/> Employer. If by the employer, please complete Question 18.																	
18. To the best of your knowledge, is the employee receiving , or is he entitled to receive, benefits from any other source - such as a salary continuance plan, other group insurance, Workers' Compensation, Social Security, Veterans Administration, retirement or pension plan, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please furnish the following information: <table style="width: 100%; margin-top: 10px;"> <thead> <tr> <th style="text-align: left;">Name and Address Of Source</th> <th style="text-align: left;">Group or Individual Basis</th> <th style="text-align: left;">Policy or Claim Number, If Any</th> <th style="text-align: left;">Exact Date Benefits Commenced or Will Commence</th> <th style="text-align: left;">Length of Benefit Period</th> <th style="text-align: left;">Amount and Frequency of Each Periodic Benefit</th> <th style="text-align: left;">Total Amount of Benefits Paid</th> </tr> </thead> <tbody> <tr> <td colspan="7" style="height: 40px;"> </td> </tr> </tbody> </table>				Name and Address Of Source	Group or Individual Basis	Policy or Claim Number, If Any	Exact Date Benefits Commenced or Will Commence	Length of Benefit Period	Amount and Frequency of Each Periodic Benefit	Total Amount of Benefits Paid							
Name and Address Of Source	Group or Individual Basis	Policy or Claim Number, If Any	Exact Date Benefits Commenced or Will Commence	Length of Benefit Period	Amount and Frequency of Each Periodic Benefit	Total Amount of Benefits Paid											
19. Remarks																	

Client / Plan No. 401 / 401000

Participating Employer _____

ASRS Employer No. _____

Branch or Affiliate _____

Telephone No. _____

Contact/Title _____

E-mail Address _____

Signature _____

Fax No. _____

Date _____

Employer Claim Statement – Part 2

Physical / Non Physical Aspects of Job

Please complete this section of the claim statement to provide us with information concerning the physical / non physical demands of the claimant's job.

Claimant's Occupation _____

Signature / Title _____ Date _____

Physical Requirements

1. In a typical work day, give the number of hours the claimant spends in each of these positions and if claimant may alternate positions:

Position	Total No. Hours	May Alternate Positions			
		At Will	15-30 Minutes	Hourly	Never
Sitting	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Claimant must	Never	Occasionally (1/4 - 2 1/2 hours)	Frequently (2 1/2 - 5 1/2 hours)	Continuously (5 1/2 - 8 hours)
A. Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Enter data/keystroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Lift: Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Carry Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Push/Pull Usual _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Max _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. On the job, claimant uses feet repetitive movements as in operating foot controls.

Right ☐ Yes ☐ No Left ☐ Yes ☐ No Both ☐ Yes ☐ No

4. On the job, claimant uses hands for repetitive action such as:

Simple Grasping	Firm Grasping	Fine Manipulation
A. Right <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Left <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Does job require:

A. Working at unguarded heights? ☐ Yes ☐ No

B. Exposure to marked changes in temperature and humidity or extremes thereof? ☐ Yes ☐ No

C. Exposure to dust, fumes, gases, chemicals? ☐ Yes ☐ No

Stress / Non Physical

- Percentage of time claimant spends answering customer complaints. _____%
- Percentage of claimant's work primarily judged on production. _____%
- Does this claimant depend upon the assistance of others in order to accomplish his/her daily tasks? ☐ Yes ☐ No _____% of time
- How many employees does this claimant supervise? _____
- Is this claimant routinely subject to close supervision? ☐ Yes ☐ No
- Percentage of time spent by the claimant working with his/her co-workers. _____%
- Percentage of claimant's time spent on: _____% Prescheduled activities
_____% Random activities
- Percentage of time claimant spends meeting deadlines set by others. _____%
- Percentage of responsibility the claimant has for the performance of his/her particular department. _____%